Healing Touch Intake Form (adapted by Miriam Lieberman)
Please use the back side of form or other pages as needed

Creating Healing Relationships
Healing Touch Program™
WORLDWIDE LEADERS IN ENERGY MEDICINE

Date: _____ Client: _____

Referred by: _____ Practitioner: Miriam Lieberman, HTCP

General Information
Address:
Phone: Email:
Emergency contact (name/phone): Legal guardian if under 18:
DOB: Age:
Education/Occupation:

Living Situation (Marital status/pets/alone; home as supportive or stressful? Social, family, personal support?):

Military Branch and years:

What change would you like to see in yourself as a result of this session?

Prior Energy Therapy/HT experienced?

Hobbies & interests:

Spiritual beliefs/practices/affiliations:

Is your belief a source of support to you? Word/Name(s) you use for Higher Power?

Your perceived strengths:

Self Care

Current self-care practices (exercise, meditation, relaxation, body care, journaling, etc):

Use scale 1-10, with 10 as an extreme issue, to rate **areas of concern.** Please describe any items rated 7 or above.

 Form HTP-902 Rev 03/07/16
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___Personal Relationships
___Physical Health
___Mental Health
___Emotional Health
___Spiritual
___Work
___Finances
___Eating/Nutrition
___Addiction

___Depression
___Mood swings
___Anger
___Anxiety
___Panic or anxiety attacks
___Trauma PTSD
___Memory problems
___Personal Direction

___Headaches
___Pain
___Fatigue/lethargy
___Hormonal issues
___Allergies
___Sleeping issues
___Safety
___Major Life Change
___Other

Relevant Health History

Current overall health condition: ___Excellent ___Very Good ___Good ___Fair ___Poor

To what do you attribute your current situation, symptom or health issue?

Last physical exam:

Current health care professionals:

Health history (list medical conditions/diagnoses, with dates/years):

Hospitalizations/surgeries/accidents/injuries (date/year/complications?):

Mental health issues or diagnoses:

Mental/emotional traumas (condition/date/year):

Current prescription/over-the-counter medications/recreational drug use:

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Supplements Used: __Vitamins __Minerals __Herbs __Homeopathy __Flower Essences __Other

Sleep quality/sleep aid usage/average hours of sleep per night:

What does the word “safe” mean to you? Do you feel safe? If so, when and where do you feel safe?

If you do not feel safe can you if you ever felt safe and what changed that?

Nutrition/Diet:

Elimination:

Daily water amount:

Caffeine/Alcohol/Tobacco/amount:

Is there **anything else** you want me to know? Any questions about me or Healing Touch?

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